Culture Counts:

Best Practices in Community Education in Mental Health and Addiction with Ethnoracial/Ethnocultural Communities

Phase One Report

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Submitted by Branka Agic

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Executive Summary

The Centre for Addiction and Mental Health (CAMH) is committed to enhancing the capacity and quality of addiction and mental health services in prevention, health promotion and treatment across Ontario. In particular, as part of both its organizational priority and through its provincial Diversity Knowledge Exchange Program, CAMH is committed to being a leader in the planning, coordination, implementation, monitoring, and evaluation of initiatives aimed at increasing the capacity of mental health and addiction systems to address the needs of diverse populations.

The proportion of ethnocultural groups within Canada's population has increased dramatically over the last few decades. Data from the 2001census reveal that 18 % of the population is foreign born, the highest proportion in 70 years, and the number of ethnic groups has exceeded 200. In the last five years, almost 80% of new immigrants arrived from Asia, Africa, the Middle East, and South and Central America.[14] The increasing diversity of the nation is reflected in a mixture of health beliefs and attitudes, substance use patterns and perceptions of potential harm. Canada is a multicultural society and multiculturalism is the view that all cultures are equal in value.[9]

A review of the literature suggests that ethnocultural groups, especially new immigrants and refugees, are relatively vulnerable to mental health and substance use problems due to pre-migration trauma, economic and social disadvantages, isolation, racism, discrimination and cultural pressures.[10,34,58] Although the level of knowledge about mental health and substance use associated problems varies both within and across ethnocultural groups, field studies among these groups found generally an inadequate knowledge of mental illness and the harmful effects of drugs.[2,14,25,60] Evidence further shows that that members of ethnocultural communities have a much lower rate of participation in health promotion, prevention and treatment programs, and are less likely to receive needed care than the general population due to systemic and service barriers which include language and cultural factors, discrimination, stigmatizing attitudes and mistrust of mainstream service providers. [2,9,14,27]

What is considered mental illness and substance use problem is largely shaped by cultural norms, attitudes, and beliefs. No single definition of "normal" drinking, problem drinking, or alcohol dependence can apply equally to all cultures.[5,6,48] Although health beliefs and expectancies of a given culture change during the acculturation process, Australian research indicates that perceptions of culturally acceptable drinking patterns are usually transposed to the host country and may require up to two generations to fully acculturate.[13]

Research indicates that programs successful in improving the health literacy of a middle-class English-speaking population may not be of use to other cultures.[43,65] There is widespread agreement that health promotion/prevention initiatives focusing on ethnocultural/ethnoracial groups require an acquaintance with the culture of the particular group.[5,39,48,61] Identifying health communication channels and sources that are considered culturally appropriate, credible and influential by the intended audience is critical to communicating health messages successfully. Evidence-based practice demonstrates that working in partnership with community groups and community-based agencies helps reach intended audience, identify culturally competent strategies and gives more credibility to the message.[11,53]

However, knowledge regarding substance use and mental health problems among ethnocultural groups in Canada is limited. Most research studies have been conducted in other countries such as Australia, the United States and England. Ethnocultural communities in Canada are not exactly like the corresponding communities in other countries.[2] They differ according to their national origin, migration experiences, social class and the level of acculturation. Furthermore, most survey instruments on alcohol consumption by ethnic minorities were developed for English-speaking people and simply translated into other languages. The quality of data obtained from surveys of non-English speakers may be compromised by a failure to compare questionnaire across languages, a failure to consider the cultural appropriateness of items for use with culturally different group, and a lack of standardization in terminology.[44,47,54] To effectively respond to the needs of diverse ethnocultural groups, the cultural aspects of mental health and substance use in a Canadian context need to be understood.

The Best Practices in Community Education in Mental Health and Addiction with Ethnoracial/Ethnocultural Communities Project builds on recent research reports and needs assessments conducted in partnership with culturally diverse communities, and health promotion/population health initiatives undertaken by CAMH. This provincial project aims to research, identify and develop a best practices model for community education and knowledge exchange in mental health and addiction with ethno-cultural communities to ensure that programs effectively address the needs of these communities.

The project is a partnership between CAMH and community-based organizations that provide services to the following groups: Polish, Portuguese, Punjabi, Russian, Serbian, Somali and Tamil. The first phase focused on low-risk alcohol use, and employed the Low-Risk Drinking Guidelines (LRDG) as the vehicle to test the best practices approach. The project is a direct response to needs identified by different ethnocultural communities for a culturally and

linguistically appropriate health education initiative addressing mental health and substance use problems including alcohol use.[14,25,42]

Over the period February – July 2004, 18 focus groups were conducted with key informants and community members from the Polish, Portuguese, Russian and Tamil communities in Toronto, the Punjabi community in Peel Region, the Serbian community in Windsor and the Somali community in Ottawa. These communities differ substantially in their cultural characteristics and religions. Not surprisingly, the focus group results displayed differences in patterns of alcohol use across the communities. The role that alcohol use plays in the lives of people, the differences in drink sizes and drinking levels that are considered "normal", "low-risk" and "excessive" and the perceptions of alcohol-related risks varied significantly among the participating communities.

Among the participating communities, alcohol use is generally viewed as a predominantly male activity, and men as the primary consumers of alcohol. Male drinking is socially acceptable within a certain degree even in the communities where alcohol is prohibited by religious norms, such as Punjabi and Somali. Consumption by women is generally lower than the consumption by men in each of the seven communities. Nevertheless, the findings indicate that alcohol consumption rates among women from the communities where women were traditionally abstainers, such as the Tamil and Punjabi communities, are slowly increasing as young women start adopting the behavior patterns of Canadian culture.

In all of the participating communities drinking is associated with social bonding and celebrations. In some communities including the Russian, Polish and Serbian communities, alcohol use is deeply embedded in their historic and cultural backgrounds and play an important role in certain functions and ceremonies. Perceptions of "normal" drinking differ considerably among the seven communities but, in general, alcohol use is considered "acceptable" as long as it doesn't cause social or family problems.

The concept of a "standard drink", which is a conceptual cornerstone of the Low-Risk Drinking Guidelines (LRDG), was unfamiliar and confusing to almost all of the participants. Focus group discussions revealed that the type and sizes of alcohol beverages consumed in each community are largely shaped by local drinking customs, which are often different from those of the dominant culture. Moreover, counting and measuring drinks is not a habit in the participating communities. The notion of a "standard drink", which applies to standard strength and unit sizes used mainly in western countries, may not be relevant to ethnocultural communities where people usually drink from a shot glass, a jug at the table, or out of bowls, and where a large portion of the alcohol that is consumed is either homemade or purchased from local/cultural markets so the actual alcohol

content is unknown. The Polish, Portuguese, Punjabi, Russian and Tamil communities supported the idea of translating the LRDG into their native languages, but also provided some recommendations with regard to the Guideline's graphics, layout and content to make them culturally appropriate and relevant. Participants representing the Serbian community felt that information about the ways to reduce the risks associated with drinking was not relevant to the their community. The Somali community found the LRDG culturally inappropriate because both their religion and culture prohibit the use of alcohol.

The LRDG are a health promotion/population level communication designed for the general population. They focus on individual choice and decision-making. By contrast, the participating ethnocultural communities seem to be more family-oriented, which impacts on the effectiveness of community health education strategies. Feedback from the focus group participants indicate that messages which stress the consequences of alcohol use on the family are considered most relevant and effective in promoting awareness of alcohol in their communities.

Focus group discussions also revealed differences in preferred and effective ways of communicating messages among the seven communities. All of the focus group participants advised that written material might not always be the best strategy for reaching out to culturally diverse communities. Communication methods that use visual images or combine oral dissemination of information with an opportunity for discussion may be more effective in conveying health messages to those communities. Ethnic mass media, especially radio and television, are considered the most effective communication channel for health promotion/prevention initiatives. Brochures are deemed more effective when they are "not too wordy", written in simple language and translated in the native language of the community. Participants also stressed that, in order to be effective, messages need to be communicated by people respected by the community, such as religious and community leaders, counselors and local physicians.

The findings reveal different levels of community readiness for alcohol prevention program among the participating communities, ranging from vague awareness to perceived need for change, which indicates that one program cannot be applied to all communities. The project's results confirm that programs that reflect the dominant culture are often not relevant to people from different cultural backgrounds. The significant differences in the participating communities' perceptions of "low-risk drinking", and their attitudes toward the LRDG demonstrate that simply translating information into another language is not an effective strategy for reaching out people from different cultural background. Messages addressing alcohol use in ethnocultural communities need to reflect local drinking practices, including types and sizes of alcohol

beverages consumed, and alcohol-related problems specific to the particular community. The results show that the development of a strong understanding of and respect for the diversity of traditions, beliefs and practices within different ethnocultural groups is essential in enabling mainstream health professionals to develop the appropriate and relevant programs for the communities with which they work. They highlight the need to create partnerships with community-based agencies and actively involve community members in the conceptualization and development stages of the health messages to ensure that both the messages and communication strategies reflect the cultural characteristics and preferences of the intended audience.

The results of the Phase One will guide the next phase of the project to culturally adapt the LRDG or develop alcohol related messages that incorporate the audience's cultural beliefs and values, and translate them in the native language of the communities. The translated materials will be pilot tested, produced and disseminated. A model for best practices in community education and knowledge exchange in mental health and addiction with ethnocultural/ethnoracial communities, the final outcome of the project, will provide comprehensive, effective and culturally sensitive approaches to meet the health promotion needs of diverse communities. In sum, the project will have served to increase access to the best approaches in addiction and mental health community education and knowledge transfer for CAMH staff, service providers and allied professionals.

General conclusions:

- Concepts that reflect the dominant culture are often not directly transferable to communities with different cultural background
- Original material, both text and the graphical elements, need to be culturally adapted to reflect cultural values and social norms of the intended community
- Direct translation, which does not take cultural concepts into account, limits the usefulness of health information
- Effective adaptation and translation require extensive testing with the intended audience during all phases of message development
- Program effectiveness also depends on the mode of delivery, which is often culturally specific
- Working in partnership with community groups and/or community-based organizations is the best strategy to ensure effectiveness of health education initiatives

1.0 Preface

This report documents the results of the first of three phases of the Best Practices in Community Education in Mental Health and Addiction with Ethnoracial/Ethnocultural Communities Project. The goal of the report is to illustrate the diversity of norms, beliefs and attitudes towards alcohol use in ethnoracial/ethnocultural communities, recognize the common barriers in accessing information and services, and identify culturally appropriate approaches in community education and knowledge transfer addressing mental health and substance use problems in these communities, including messages focusing on reducing risks associated with drinking. The report will provide the basis for the development of a Best Practices Manual and a set of guiding principles to be used by service providers to direct their outreach to ethnocultural communities.

Best Practices in Community Education in Mental Health and Addiction with Ethnoracial/Ethnocultural Communities Project is a direct response to identified community needs for a culturally and linguistically appropriate health promotion initiative addressing metal health and addiction issues. It builds on recent research reports and needs assessments conducted in partnership with culturally diverse communities, and health promotion/population health initiatives undertaken by the Centre for Addiction and Mental Health (CAMH):

- **Research into best practices in community education/health promotion with ethnoracial/cultural communities** undertaken in 2003 serves as the first phase of research required for this project. The report indicates that health promotion programs designed for the general population usually do not reach diverse ethno-cultural groups. The provision of culturally responsive and linguistically appropriate health promotion programs is necessary to raise awareness on mental health and addictions issues in ethno-racial/cultural communities and ensure equal access to all the resources.
- **CAMH's Building Bridges Breaking Barriers (BBBB) Access Project,** the results of which highlight the need for culturally appropriate health promotion and community education initiatives in addiction and mental health. The community consultations identified a lack of broad health promotion strategies as well as funded programs, brochures and information fact sheets addressing mental health and addictions issues in five ethnoracial/cultural communities: Polish, Chinese, Tamil, Punjabi and Ethiopian. The Project Management Team recommended that Education & Health Promotion (E&HP) formally partner with community based service providers, ethnoracial/cultural community leaders, and schools to develop a community education strategy addressing "critical and relevant" topics using a community development strategy.
- **The results of the first phase of the "Health Promotion and Prevention Action Plan for French-Speaking Communities Project** and the resultant findings from the report

"Open Windows, Opening Doors: Ethnoracial/Ethnocultural Communities Addiction and Mental Health". The study recommended that CAMH institute a campaign that integrates the production of linguistically and culturally sensitive educational materials.

- **Low-Risk Drinking Guidelines (LRDG)** and ways in which they can be culturally adapted based on best practices. CAMH, the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA) first released the LRDG in October 1997. The LRDG are based on general health promotion / population health principles and offer advice to healthy adults on low-risk drinking founded on a very comprehensive review of international research that examined the long- and short-term effects of alcohol for health and safety.

This project aims to research, identify and develop a best practices model for community education and knowledge exchange in mental health and addiction with ethnoracial/cultural communities, to ensure that programs effectively address the needs of people from different cultural and linguistic backgrounds. The project is built on a community development approach to health promotion applying a community readiness model for the prevention of substance use problems. This model is an effective method for assessing the community's level of problem awareness and readiness to address the problem. In order to be effective, health promotion/prevention interventions introduced in a community must be consistent with their level of readiness to change and develop and implement particular program.[65]

The project has been developed in partnership with seven community organizations: Polycultural Immigrant Services, Society for the Aid of Ceylon (Sri Lanka) Minorities - SACEM, Vasantham - A Tamil Seniors Wellness Centre, and Portuguese Mental Health and Addiction Services, Toronto Western Hospital from Toronto; Punjabi Community Health Centre, Peel Region; The Multicultural Council of Windsor-Essex County and The Somali Centre for Family Services in Ottawa. The partnering organizations represent the following ethnoracial/cultural communities: Polish, Portuguese, Punjabi, Russian, Serbian, Somali and Tamil. Community needs assessments studies conducted in these communities have identified alcohol as a serious problem that needed to be addressed. All seven communities expressed the need for health promotion strategies that integrate their cultural and religious norms and values.

<u>Project Objectives:</u>

- To identify common barriers to accessing health information among ethnocultural communities
- To identify appropriate approaches to effective community education and knowledge transfer, which reflect principles of equity and access

- To apply appropriate approaches to culturally adapt the Low-Risk Drinking Guidelines (LRDG) and/or develop messages focusing on low-risk drinking in an effort to ensure the effectiveness of the approaches

The focus of Phase One of the project was on low-risk alcohol use, and the LRDG were employed as the vehicle to test the best practices approach. The information presented in this report will be used in the next phase of the project to culturally adapt the LRDG or develop culturally appropriate public education materials addressing alcohol use in respective communities. The materials will then be translated, field tested for comprehension of the information, produced and disseminated.

2.0 Methodology

In order to arrive at a more complete understanding of the issues related to providing comprehensive, effective and culturally sensitive approaches that will meet the health promotion needs of diverse communities, the project had four main components:

- A review of the relevant literature
- Consultations with the representatives of the partnering organizations
- Focus group discussions with key informants
- Focus group discussions with community members

The first task of this project was the completion of a comprehensive literature review including published studies in Canada and international jurisdictions pertaining to cultural aspects of alcohol use, access barriers to health promotion/prevention initiatives, and effective community education strategies within different ethnocultural/ethnoracial communities. The literature review provided a framework for the cultural patterns of alcohol use and established a basis for the next steps in the project's implementation.

The subsequent tasks included a series of consultations with community partners who provided crucial information on the cultural background of each community, cultural patterns of drinking, perceptions of alcohol related problems and the best way to identify culturally relevant and sensitive alcohol related messages. This work involved joint discussions on the focus group plan, design, discussion guide and strategies for recording and analyzing the information collected within the focus groups.

The next step was to organize and conduct focus groups in all seven communities. Focus groups are considered an excellent tool for gaining insights into people's shared beliefs, perceptions and attitudes, and provide a forum for revealing information such as cultural values or group norms. It is a particularly useful method for exploring understanding of illness and of health behaviors, and is often used in cross-cultural research and work with ethnic minorities.[64] Focus groups are an effective way to test health education materials and are widely used in developing or modifying translations or back translations of interview instruments or health information. They help service providers identify messages that are relevant and most appealing to the audience, ones that are most understandable and culturally appropriate. Some researchers note that group discussions can generate more critical comments than one-to-one interviews, especially when working with disempowered populations.[77]

The main purpose of the focus group discussions was to identify cultural aspects of alcohol use, as well as culturally appropriate and relevant messages regarding low-risk drinking. The discussions also focused on community perceptions of the most effective types of health promotion programs and program components including content, language and means of communicating the messages within participating ethnocultural/ethnoracial communities. The information obtained from the focus groups will be used to develop community education messages effective in promoting low-risk alcohol use and/or adapt the LRDG to be culturally relevant for the respective ethnocultural group. In communities where abstinence from alcohol is a cultural norm, the project aims to reduce the risks associated with alcohol use among people who choose to drink.

Two focus groups per community were conducted; one with community members and one with key informants. Key informants were selected for their influence, knowledge and experience in the areas related to the cultural aspects of alcohol use, health education and the prevention of problems associated with alcohol. They included community, religious and political leaders, health professionals, small business and service providers who have knowledge about the germane issues and work with the respective communities. In order to gather a wide range of input, the organizers made an effort to enhance the heterogeneity of the focus groups' participants with respect to age, gender, socio-economic status and length of residency in Canada. In the Punjabi and Somali communities, separate focus groups with men and women were conducted based on the recommendations provided by the community partners as it was considered culturally appropriate and a more effective way to obtain valuable information.

The focus groups were held at either the partnering organization's premises or other locations familiar to the participants. A bilingual staff member from the partnering agency facilitated the session. Focus groups were conducted in the participants' first language in order to hear the voices of people who are not fluent in English and face both cultural and linguistic barriers in accessing services. This segment of the population is often neglected by researchers and program planners, and rarely given an opportunity to express their needs and concerns. Each focus group met one time for about two hours of discussion. At the beginning of the session, the participants were informed about the project's overall goal, the focus group session and specific ground-rules of group participation. A semi-structured focus group discussion guide had been developed to assist the facilitation of both the key informants and the community member sessions (please see appendix 1). Its purpose was to evoke group responses and focus the discussion on the project's subject of interest.

While tape recording has the advantage of capturing data more reliably than written notes might, and can make it easier for the researcher to focus on the interview, experience from other projects found that tape-recording is not the preferred method of data recording with ethnocultural/ethnoracial communities. To ensure that all relevant information was recorded, two people were responsible for taking notes during the focus group discussions. Recorded data were transcribed in full and then translated. Although full transcription is time consuming and may be impractical, when the interview involves translation from one language to another, this may be the preferable approach.[64]

Information generated by the focus groups was analyzed using a phenomenological approach, which included both content and thematic analysis. Special attention was paid to the cultural meanings of the information so that results could be used to tailor future addiction prevention and treatment approaches to the particular needs of the target community.

2.1 Limitations

Focus groups participants are not a representative sample selected from a particular ethnocultural population but rather a group of people who either embody the characteristics or live in circumstances relevant to the phenomenon being investigated.[45] It is necessary to keep in mind that we cannot accurately define the drinking pattern of the entire ethnocultural community based on the findings obtained in one region. Generalizations of the findings must always be made with great caution since the purpose of the focus groups is not to generalize, but to gain insight and depth of understanding.[29,45]

As noted above, the focus groups proceedings were recorded by note taking rather than audio taped. This is a limitation as scribes may not always be able to capture all the information. In addition, English translations of discussions may compromise the accuracy of the discussion recorded as some terms and expressions that exist in English do not necessarily exist in other languages and cultures, making exact translation into English not always possible.

3.0 Review of Research Literature

Perception of mental health, mental illness, substance use and related problems is largely influenced by cultural factors. Mental disorders have similar symptom profiles across cultures, but the ways in which people communicate their symptoms and which ones they report vary among ethnocultural groups.[16] What is considered a "drug" is also culturally specific. Individual substances may have different meanings in different societies. Cultural factors are among the key determinants of health. Culture determines whether and when people seek help, what types of help they seek and the level of stigma they attach to both mental illness and addiction.[33,43,58,62] Meanings that people give to mental health/illness and substance use problems determine the effectiveness of health promotion programs designed to prevent or reduce those problems.[72] However, our health system doesn't adequately understand and respond to these issues, which indicates that people from culturally and linguistically different backgrounds, particularly the first generation immigrants, do not access services on equitable basis and are less likely to be adequately informed on health related issues.[2,14,58]

3.1 The Purpose and Scope

The purpose of the literature search was to review research on socio-cultural aspects of alcohol use and best approaches to community education and knowledge transfer with ethnocultural communities including:

- Patterns of alcohol use among diverse ethnoracial/cultural groups
- Cultural norms, attitudes and beliefs regarding drinking including expectations regarding the effects of alcohol and culturally mediated stigma
- International drinking guidelines
- Patterns of information and treatment seeking
- Effective health promotion/prevention efforts within different ethnoracial/cultural groups and the best ways to convey those messages
- Culturally appropriate development and adaptation of health promotion interventions within culturally and linguistically diverse groups

This section provides a summary of the key findings on this topic from international research as well as published reports on studies conducted in Canada. A literature review revealed that the published research on cultural aspects of alcohol and other substances use in Canada is scant and, in some cases, outdated. Currency of information impacts the service providers' ability to accurately identify alcohol related problems in the community.[58] Culture is dynamic and is influenced both by peoples' beliefs and the demands of their environment.[58] Acculturation, the

adoption of the behavior patterns of the host culture, influences changes in norms, beliefs and health behaviors, and may relate either positively or negatively with people's attitudes toward substance use.[49,56,79] Australian research indicates that traditional cultural beliefs and perceptions of socially acceptable drinking patterns are usually transposed to the host country and may require one or two generations to fully acculturate.[11]

Most research studies on alcohol issues in ethnocultural/ethnoracial communities have been conducted in other countries such as Australia, United States and England. However, ethnocultural communities are not homogenous groups. They differ according to their national origin, migration experiences, social class and the cultural influences of the host country.[58] Ethnocultural/ethnoracial communities in Canada do not necessarily compare with the corresponding communities in other countries and broad generalization cannot be made.[2] Comparing the results of different research studies on addiction is also difficult because of different methodologies and little explanation as how the sample was obtained.[34] Furthermore, most surveys on alcohol consumption by ethnic minorities use instruments developed for an English speaking population, which are often not culturally and linguistically appropriate for minority populations.[7] Cross-cultural adaptation of instruments is considered a prerequisite for the investigation of cross-cultural differences.[30]

The proportion of ethno-cultural groups within Canada's population has increased dramatically over the last few decades, mainly as a result of changing patterns in the origins of immigrants from regions other than Europe. Approximately 230,000 immigrants from all parts of the world arrive in Canada every year. Based on the 2001census, 18% of the population is foreign-born, the highest proportion in 70 years. The visible minority population reached 4 million, a three-fold increase over 1981, and the number of ethnic groups exceeded 200. The increasing diversity of the nation challenges Canada's health care system to effectively respond to the diversity of health knowledge, needs and expectations.[20,71]

Problems associated with alcohol use cross ethnic, socio-economic and cultural barriers. Although significant differences exist between the countries of origin in relation to alcohol-related problems, available evidence indicates that alcohol is a serious problem in many ethnocultural communities.[50] Although the level of knowledge varies both within and across ethnoracial/cultural groups, field studies found that there is generally an inadequate knowledge about the harms associated with alcohol use.[14,27,60] Research also shows a lower rate of participation for ethnoracial/cultural communities in health promotion/prevention programs due to barriers that are consistent with barriers identified for other health services.[9,14,31,48]

The importance of participation by ethnic communities in the development of addiction prevention, harm reduction and treatment initiatives has been well recognized in the literature.[18] Strong understanding of the cultural patterns of drinking is essential in enabling health professionals to develop culturally appropriate health promotion interventions.[58,66] Evidence further shows that support for a health promotion initiative increases if the community participates in the development and implementation of appropriate strategies to address particular problems.[39,43,72]

3.2 Alcohol and Culture

Alcohol has been the most common intoxicating substance in almost all cultures for centuries. However, perceptions of alcohol and patterns of drinking vary widely among ethnocultural/ethnoracial communities.[39,48,58] This includes preferred types of beverages, drinking levels that are considered normal, and population subgroups for which drinking is considered acceptable. In some cultures, alcohol is viewed as part of the daily diet and in others as a dangerous and harmful substance.[56] In many cultures, alcohol is a common ingredient in home remedies. For example, to regain strength after giving birth, Cambodian women traditionally drink a white wine mixed with different herbs.[32] Alcohol use is widely accepted for promoting relaxation and sociability in some cultures. Many cultures serve alcohol as an expression of hospitality. Alcohol is also part of ritual or festival drinking in some cultures.[2,27] For example, among some sects of the Catholic Church, the consumption of wine is an integral part of the celebration of mass.[33,49] By contrast, in abstinence-based cultures, alcohol use is strictly prohibited under any circumstances.

In many cultures young people are introduced to alcohol early in life as a normal part of daily living. For example, in Mediterranean countries such as France, Italy, Portugal and Spain, children are routinely given wine as part of a meal or celebration.[32] Most cultures impose some restrictions on “underage” drinking, but both the definitions of “underage” and the nature of the restrictions vary widely. The legal drinking age ranges from 21 in some countries including the United States, Malaysia, and Korea to 16 in countries such as Italy, France, Belgium and Spain. Many countries, including China, Portugal and Thailand currently have no established legal limits.[36]

Australian research found that “non-English speaking” communities are reluctant to classify alcohol as a drug and tend to keep drinking problems in the family due to the shame and stigma attached to addiction.[60]

Literature reviews also show some genetically-determined variations in the body's ability to metabolize and eliminate alcohol among some ethnocultural groups that directly affect their alcohol consumption rate. Approximately 50% of people from an oriental background, including Chinese, Japanese, and Koreans, have a deficiency or absence of the liver enzyme, alcohol dehydrogenase (ALDH). These people experience vomiting, flushing, and increased heart rate after consuming alcohol. Subsequently, they tend to drink less and are at lower risk for alcoholism, and are three times more likely to be abstainers than Asian males who possess the more active enzyme.[35] By contrast, some other groups are at an increased risk for alcohol addiction. For example, Native Americans, a population with a high incidence of alcoholism, generally don't become intoxicated as quickly as other races and therefore may tend to drink more.[75]

Religious norms also influence drinking practices. The major religions have differing views on alcohol use. Christianity and Judaism accept alcohol use for social purposes while Islam, Buddhism and Sikhism prohibit its consumption. The Hindu religion generally disapproves of alcohol consumption but seems to condone its occasional use by certain classes (Kshatria Caste) of people.[52] However, in spite of the religious norms, social stigma and serious cultural reservations, the use of alcohol has gradually spread to most ethnocultural communities, and complex patterns of alcohol use already exist within these communities.[32,58]

Cultural traditions also shape perceived reasons for alcohol use. Research indicates a growing trend in some communities, such as the South Asian community in the United States, to view alcohol as a symbol of being modern and a requirement for "having a good time", and any suggestion that this is dangerous behavior is often ignored.[58] A needs assessment study conducted in British Columbia with four ethnocultural/ethnoracial communities revealed that Latin Americans chose alcohol as a stress reducer, Indo-Canadians viewed alcohol as a status symbol, while the Chinese community traditionally used it for health and medical purposes.[2] A study that conducted cross-cultural analysis drinking patterns in India, Mexico and Nigeria found that people’s perceptions of who or what was responsible for a person’s alcohol use differed significantly among countries and different cultural groups even within one country. For instance, the authors found that in India normal drinking was described as the consumption of small quantities of alcohol that did not interfere with person’s responsibilities. In Mexico, men are expected to drink large quantities of alcohol to be considered “macho”.[6]

The concept of “standard drink” has been a central feature in alcohol education campaigns, mainly in English-speaking countries. Research findings indicate that using measures of alcohol consumption formulated for the dominant majority culture may be problematic in culturally diverse communities because the standard drink equivalents may be less relevant and even confusing to

some ethnic groups.[37,58]. International research found significant differences among countries in how much alcohol is contained in one “standard drink”, which makes it difficult to compare drinking behavior and its consequences across countries. It ranges from the equivalent of 8 grams of ethanol in the UK to 19.75 grams of ethanol in Japanese standard drink.[37] Commercial measures of most alcohol beverages also differ across countries, and alcohol content varies among different beers, wines and distilled spirits. In addition to this, drinking often occurs in private settings where the size of drinks poured does not correspond to standard units, therefore making it difficult to determine the number of “standard drinks” consumed. For example, in the Punjabi community a good host does not measure drinks, while a good guest accepts the host’s offer of alcoholic drinks.[79,80]

Research results suggest that the concept of addiction is a cultural construction. A study by the World Health Organization of the cross-cultural applicability of criteria for the diagnosis and assessment of substance use disorders conducted in nine countries found that the main criteria for the diagnosis of substance use disorders are not applicable to all societies due to different cultural attitudes toward substance use. The baseline for identifying and defining addiction varied significantly from one site to another. In many cultures tolerance for alcohol was not seen as a symptom of problematic drinking, but in fact held a positive connotation.[68] The study found that the concept of impaired control is relevant in the Western cultures where the individual is viewed as being responsible for control of his or her own life. However, it makes less sense in cultures where the individual is seen not as autonomous but rather as intimately integrated with his or her extended family and environment.[67] Research indicates that perceptions about what behavior is considered a problem in a particular culture should be considered as a potential indicator of addiction.[68,32]

3.3 Barriers in Access to Alcohol Education Programs

Evidence suggests that cultural background reflected in the norms of alcohol use, the migration experience, inter-generational problems, social class, social adjustment and the level of acculturation, are important factors in understanding the attitudes toward alcohol and other drugs in diverse ethnocultural communities. Studies conducted in the US, Australia as well as in Canada found generally poor knowledge among culturally and linguistically diverse populations regarding the effects of alcohol, which indicates that these groups may be at higher risk of alcohol-related harm than the general population.[3,59,60] Some authors suggest that ethnocultural/ethnoracial groups are relatively vulnerable to substance use problems due to economic and social disadvantages, and cultural pressures.[48,58,60] Certain subgroups, such as new immigrants and refugees, those who have suffered severe pre-migration trauma due to war

or displacement or experience adaptation problems resulting from culture conflict or lack of personal resources, are at increased risk of developing addiction problems, especially during the first few years .[5,18,60] Cultural norms that discourage open discussion of alcohol issues put members of these communities at additional risk of alcohol related harm.[58]

International studies show that ethnic minorities suffer a greater loss to their overall health and productivity due to the inadequacy of health services in meeting their needs.[5,58] Research finds that the lack of English and literacy skills, different cultural norms and beliefs, differences in communication styles, stigmatizing attitudes, plus racism and discrimination often prevent members of ethnocultural/ethnoracial communities from accessing health promotion/prevention programs.[9,39,60]

Health promotion programs that target the general population do not reach out to diverse ethnocultural/ethnoracial groups. One of the main reasons is that the majority of health education materials and programs reflect only the cultural values of the majority.[48,59] Cultural beliefs and values influence people to either reject or accept the information that the program provides.[54] Qualitative research studies identified the lack of cultural knowledge among mainstream service providers, and the language and health messages that differ from people's own beliefs and traditions, as the main barriers in accessing programs. Results emphasized the need for coordinated, culturally-sensitive and linguistically appropriate health education strategies that address mental health and addiction issues in ethnoracial/cultural communities. [2,14,26,27,39]

3.4 Best Practices in Cross-Cultural Community Education

Best practices in health promotion are "those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories/beliefs, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation" (Kahan and Goodstadt, 2001). Best practices have been proven through research and evaluation to be effective at preventing and/or reducing health problems.

Understanding cultural patterns of substance use, the community's attitudes and expectations regarding its effects, perception of mental health, illness and treatment services is crucial for improving and addressing substance use and mental health needs of ethnocultural communities. To be effective, health messages need to be culturally-sensitive and relevant to the community; pictures and music from the respective culture should be used in health education materials and other communication tools.[2,39,48,58,60]

Community input is essential to understanding substance use and mental health issues in ethnocultural/ethnoracial communities. Working in partnership with community groups and community-based organizations is the best strategy to meet the needs of culturally diverse communities and ensure effectiveness of any education initiative.[11,35] The community groups play a bridging role by improving the accessibility and communication between their members and mainstream service providers, particularly where cultural or language barriers may prevent people from making use of community services.[66] They also bring expertise and credibility that the program needs to be effective in increasing the community's knowledge of a health issue and influencing health behavior change.[53]

For example, abstinence from alcohol is a value that is deeply rooted in some cultures and religions, and may be the only approach to alcohol use considered religiously, culturally and socially appropriate. Ideas like "sensible drinking" will succeed in these communities only if health professionals work closely with the religious or community leaders who have direct access and special roles in their communities.[58]

Determining the community's level of readiness to implement a particular health promotion/prevention program should be the first step in program planning. Community readiness is the extent to which a community is adequately prepared to implement a health promotion or prevention program. It ranges from complete denial to high level of awareness and sophisticated knowledge of the risk factors and etiology of the problem.[55,72] The community readiness theory is based on the assumption that communities, using a step by step method, can be mobilized to develop and implement effective prevention programs.[72] If a community is at the stage of denial and does not recognize that the certain behavior "is or can be a problem", it will not have the support and commitment of its members necessary to implement a successful prevention initiative.[12] The community's level of readiness indicates what type of program may be effective.

Research evidence demonstrates that existing programs designed for the general population need to be culturally adapted in order to reach out to diverse communities. Concepts that reflect the dominant culture are often not directly transferable to communities with different cultural background.[66] Culturally sensitive health practice is now a growing emphasis in most Western countries, especially ones that have accepted large numbers of immigrants, refugees and guest workers. Cultural competence in health care is also increasingly on the international health agenda, especially since both the World Health Organization and UNESCO declared 1996 to be the year of 'Culture and Health'.[58]

In the US, two alcohol prevention programs that had demonstrated success in the general population, the Strengthening Families Program and the school-based Life Skills Training Program that focus on urban African Americans and Hispanics, have been modified to be culturally relevant for specific ethnic groups. The modified programs have been found to be more effective in reducing alcohol consumption and family problems among target communities than the generalized approach.[56]

A number of health organizations in Canada have also undertaken steps to adapt the content of their programs for use with a variety of ethnocultural groups. The Canadian Diabetes Strategy is a project designed to improve newcomers access to diabetes information and social support for people with diabetes, and their families, in the Vietnamese, Latin American, Chinese, South Asian and African communities. Canada' Food Guide to Healthy Eating Cultural Adaptation, Translation and Validation Project is another health education initiative adapted to be more culturally appropriate for different ethnoracial/cultural communities.[73] In 1994, the Addiction Research Foundation, one of the founding partners of CAMH, developed a health promotion program **"**To Your Health". The program was designed to reduce the risks associated with alcohol consumption among middle-aged men in Italian and Portuguese communities, and was based on a community development approach in order to ensure that cultural values and social norms within the Italian and Portuguese communities were reflected in the program's activities and materials.[1]

3.5 Culturally Appropriate Communication Strategies

Effective communication is the key to successful health promotion and prevention efforts. The capacity of health messages to reach out to diverse communities depends largely on the strategy used to convey the information to the intended audience.[53] Health communication strategies that effectively raise awareness and influence members of culturally diverse communities to change their behaviors are based on an understanding of the social and cultural contexts that shape the health behaviors of the intended audience.[35,54] Evidence shows that strategies frequently used in English-speaking health campaigns are not relevant to culturally and linguistically diverse communities. Moreover, a strategy effective in one community may be unsuccessful in another because preferred ways of communication are culturally-specific.[11,14,22] Having a large number of different ethnocultural/ethnoracial communities requires service providers to consider various methods to deliver health education messages.

Literature suggests that oral forms of communication such as ethnic radio, television, lessons in English-as-a-Second-Language (ESL) classes and presentations led by the persons respected by

the community have been proven to be effective in disseminating health information to ethnocultural/ethnoracial communities.[25,58] Ethnic media, in particular radio and television, have the ability to reach very large audiences and successfully promote awareness among local community members about the importance of a particular health issue.[11,14,28] Community health education initiatives have been effectively organized around local festivals and celebrations incorporating different types of ethnic music and art into the activities. For example, in Asian culture, food is very important and programs incorporating a community lunch have been successfully used to convey heath promotion messages.[47] Workshops and dramatization are also considered effective communication channels. This type of communication has the same potential as the local media since it reaches a large audience. It also provides opportunity for interaction, which is preferred way of communications in some communities such as Chinese or Tamil.[14]

Telephone, CD-ROM, and the Internet have been widely used and in many instances have replaced traditional communication tools such as written materials and one-to-one communication.[53,35] However, research indicates that diverse populations have underused telephone-delivered messages. Recorded messages are often confusing to people of different linguistic backgrounds, especially those not fluent in English. For some groups, especially recent immigrants from rural areas, telephone conversation can not replace in-person communication, and information received by telephone may not be considered credible.[18,38] Language barriers seem to be the main issue that prevents people to access telephone-delivered messages. The Internet is one of the most powerful communication tools, but a large number of people still lack access to it due to barriers such as cost, low literacy, limited English language proficiency and a lack of culturally appropriate information. Recent studies found ethnic and age differences in attitudes towards Internet use. In general, older people are less likely than younger to use it.[18] In addition, people with mental or physical disabilities are less likely to use the Internet than others.[30]

Printed materials, such as posters and brochures, designed for the general population are often irrelevant to culturally diverse groups. To be effective, they need to use graphics and pictures that reflect the cultural background of the intended audience.[24,51,54,61] It is important to keep in mind that specific colours hold special meaning in some countries. For example, red stands for good luck and happiness in Chinese culture. Black is strongly associated with mourning throughout the Western world, but in certain oriental cultures, it is white that signifies mourning. In American culture, blue is for boys while pink is for girls, but this symbolic use of colour is not shared by many cultures.[76] Therefore printed materials need to be developed in collaboration with the

respective community and tested with the intended audience to make sure that the colours and graphics are culturally appropriate.

Research indicates that health resources need to be available in the language of the population being served, reflecting the educational and literacy level of the target audience as well as the dialectic and cultural nuances of the target population.[11,22,61] Language is identified as one of the greatest barriers in access to health programs for people of non-English speaking background. Language barriers in Canada are generally considered to be “newcomer” and “settlement” issues.[24,61] However, evidence shows that a significant proportion of immigrant populations have difficulties fully understanding health information. The Report on Language Barriers in Access to Health Services (2001) states that, at least, 1 in 50 Canadians requires an interpreter for health care, but it is believed that this number is actually much higher. Language barriers, if not addressed, create a risk of individuals misinterpreting key concepts and misunderstanding health information.[9]

Ideally, health education resources should be originally developed in the target language based on focus group discussions with community representatives to incorporate an appreciation of the cultural norms of the community. This process is especially important when the materials are to be used to motivate behavior change, as in health education and disease prevention initiatives. They can then be translated into English for review and reference purposes by the health care provider.[23] More often English language materials are translated into another language. Research findings indicate that when translating health materials into another language, translation and back-translation procedures are not sufficient to obtain culturally equivalent information.[51,54] For example, in the Chinese and Japanese languages there is no word that is equivalent to “depression” in Western languages.[16] Moreover, messages that reflect the dominant culture are not always directly transferable to culturally and linguistically diverse communities. Information may be irrelevant or unintelligible to a person who has a different cultural background.[28,35,40,51] Those who work with culturally diverse groups recognize that direct translation which does not take cultural concepts into account limits the effectiveness of health information.[28,54,61]

An extensive body of literature stresses the need for cultural competence in the context of health care which includes cultural adaptation of the English health materials.[11,44] Term “cultural adaptation” is used to encompass a process that looks at both translation and cultural adaptation issues in the process of preparing resources for use in another setting.[23,44,54] It is the process of adjusting health messages to the intended audience incorporating their cultural heritage, language and ethnicity. Sometimes it means finding the right word. On other occasions, it is about finding cultural equivalence so that information is relevant and understandable to a different cultural audience.[51,54,46] It may also include changing the design and layout of material because

colours, symbols and graphics can have various associations in other cultures and many people react subconsciously to a message due to the style in which it is presented.[22,23,24,51,74] Literature-based evidence, including the internationally recognized standards and guidelines for developing multilingual health information, recommends a three-phase process in developing culturally appropriate health education materials:[51,61]

- Cultural adaptation
- Translation
- Cultural validation

Lessons learned from international experiences as well as Canadian health education programs stress that the revision of materials at multiple levels is essential for developing culturally appropriate initiatives.[51,54,61] The intended audience should be intensely involved in the conceptualization and development stages of the health messages.[23,66,74] Evidence suggests that selected English material be reviewed by the primary audience and professional intermediaries to determine relevance of the information, cultural appropriateness and the required level of cultural adaptation. Original material, both text and the graphical elements, should be culturally adapted based on the recommendations provided by community members and service providers, under the condition that proposed revisions to the original material would not compromise the accuracy of the information. The translation protocols indicate that the initial draft needs to be evaluated for clearness and comprehensiveness by the service providers, native speakers of the receptor language. On the basis of the feedback received, a revised draft should be developed. The next step is to test the message with the intended audience, both primary (community members) and secondary (intermediaries), and to view the information from the audience's perspective to ensure its effectiveness. This process helps refine messages and materials so that they are relevant, culturally appropriate and understandable to the intended audience.[44,51,54,61]

When the original document developed in English is translated into another language, meaning must have priority over form in translation. The Minnesota Department of Health (MDH) Translation Protocol, 2000 states that the best translation is one that:

- Uses the normal language forms of the target language
- Communicates as much as possible the same meaning that was understood by the speakers of the source language text to the target language speakers
- Maintains the dynamics of the original source language text, which means that the translation is presented in such a way that it will evoke the same response as the source text attempted to evoke

Research shows that when developing a community health education program addressing substance use or mental health issues, it is necessary to identify the most credible communicators within the particular ethnic groups, and the communication channels (e.g. print, television, radio) that have the most impact. Within ethnic communities, institutions such as churches, temples or mosques, local businesses, schools and local political bodies play important roles in addressing alcohol problems.[58,60,66]

Tailored communications have been proved to be more effective because they have specific appeal and are clearly understandable to the audience. Most recommendations for the development of cross-cultural health education resources are based on international experiences in health promotion/prevention planning.[48,53] However, there are issues related to program delivery that are unique to Canada's multiculcultural society, and the best practices approach effective in other countries needs to be "tested" for effectiveness among diverse communities living here.

4.0 Summary of the Focus Groups Findings

During the period February – March 2004, a total of 18 focus groups were conducted with community members and key informants from seven ethnocultural/ethnoracial communities in Ontario: Polish, Russian, Portuguese and Tamil in Toronto, Punjabi in Peel Region, Serbian in Windsor and Somali in Ottawa. Eight focus groups were conducted with key informants and ten with community members. The participating communities have distinct cultural and religious backgrounds, including traditions of alcohol consumption, drinking practices and beliefs about alcohol. The focus group discussions aimed to identify alcohol consumption patterns, cultural practices and culturally appropriate and effective health promotion strategies to address substance use and mental health issues within participating ethnocultural/ethnoracial communities. Major findings from the project's first phase are rich in their potential to identify and describe elements of best practices in community education in mental health and addiction with culturally diverse communities.

The focus group discussions attended to the following issues:

- Community's view and attitudes toward the use of alcohol
- Local drinking practices, including the most common kinds of alcohol beverages consumed, the size of glasses/containers in which they are usually served, and the socially acceptable amount of alcohol consumed on one occasion
- Differences in drinking patterns between the country of origin and Canada
- Community's perception of the risks and problems associated with drinking
- Community's perception of low-risk drinking
- Culturally appropriate and effective messages addressing alcohol use
- Perception of the Low-Risk Drinking Guidelines (LRDG)
- Community specified means of communicating health messages most effectively

4.1 Community's view and attitudes toward the use of alcohol

Focus groups findings reveal varying degrees of alcohol acceptance in the participating ethnocultural/ethnoracial communities ranging from total prohibition in the Somali community to wide acceptance in the Russian, Polish and Serbian communities. They also show that although some communities have religious sanctions against alcohol, drinking still takes place within certain degrees of social acceptability. For example, in the Somali community alcohol is prohibited by both social and religious norms, and drinking is viewed as a shameful activity. Nevertheless, focus group participants noted that male drinking was still socially acceptable. Sikh

religion* also prohibits the use of any intoxicant, but the findings reveal that alcohol use in the Punjabi community is widespread and Punjabi men are viewed as "heavy drinkers". "*Every birthday party, wedding or picnic is associated with alcohol consumption. Men also drink after coming home from work. Alcohol is used to 'relax' or relieve 'stress'*." Hinduism, the major religion in the Tamil community, strongly condemns alcohol use, but, according to the participants, "drinking" is generally socially accepted. On the other hand, in the Polish, Russian, Portuguese and Serbian communities, alcohol is considered a part of their cultural traditions and is evident in all aspects of their social fabric. "*It has been part of rituals, special events and holidays throughout Russian history.*" (Russian community member)

In some cultures, alcohol consumption has a special meaning and plays an important role in certain functions and ceremonies. Analysis of the focus group discussions reveal that for five communities, Polish, Russian, Portuguese, Serbian and Punjabi, offering alcohol to a guest as well as accepting a drink from a host is perceived as a "social norm", a sign of hospitality and respect. "*A host feels obligated to provide drink to a guest as this is considered a sign of respect. A guest is expected to accept his host's offer of alcoholic beverages*." (Punjabi community member). At the reception following a funeral in the Serbian and Tamil communities, it is traditional that each person has one drink as "they enter in memory of the deceased".

- **Cultural taboos around "problematic" alcohol use**

In all communities there is stigma attached to alcohol-related problems. Therefore, these are often kept secret within a family and seeking help is delayed as long as possible. "*The society may know that the person drinks, but it keeps silent until the addict's problems become open to the public, i.e., health, finances, loss of job, family break-down, and it is too late for repair. It stigmatizes both the person and his family. This means hesitation to marry their children or have financial transactions with them." (Tamil key informant)* To avoid stigmatization and keep the problems of alcohol abuse within the family, women tend to endure their husbands' abuse and suffer in silence. Women in the Punjabi focus group stressed their unequal position in the family and their inability to influence change in their husbands' drinking habits.

4.2 Local drinking practices

In almost all seven communities, alcohol is frequently used as a coping mechanism during times when people are dealing with problems. "*There are psychological reasons to drink, such as bad news, family problems, depression and stress*." (Polish key informant) There is also a common belief that alcohol is good for one's health, and health reasons are frequently provided to justify

* Punjabi focus group participants represented Sikh community

consumption. *"It decreases a risk of heart attack. It is also good to drink before meal so that we can enjoy eating food."* (Punjabi key informant) "*We have a toast: For good health*." (Russian community member) In the Tamil community, alcohol is used as a remedy: brandy is traditionally given to women for the first few days after childbirth to help "relieve body pains and regain energy that is lost during childbirth".

In all the participating communities, alcohol is most frequently used for socializing and entertaining purposes. Alcohol seems to play an important role in male bonding. "*Men often come back to the bar after a soccer game. There is no cheap liquor in the social (Serbian) centre but they gravitate here because of the social aspect – to socialize with other men."* (Serbian key informant)

- **Drinking patterns**

Undoubtedly, in all seven communities, alcohol use is viewed as a predominantly male activity. Even in communities where use of alcohol is socially acceptable for both men and women, different norms apply. Women are either not expected to drink at all, such in Somali, Tamil and Punjabi communities, or expected to have one to two drinks on special occasions. "*Women have to take care of the family."* (Russian community member) Women who publicly consume more than the socially acceptable amount of alcohol are usually ostracized. "S*ociety has less respect for women who drink than it has for men*". (Polish community member) Women are also expected to stay sober and take care of their intoxicated husbands. *"(At social events) Men will drink and women will drive."* (Serbian key informant) However, findings indicate that in fear of being stigmatized women often hide themselves when drinking. "*They use coke to dilute the drink, so everybody thinks that they are drinking coke.*" (Punjabi community member) Participants from the Punjabi and Tamil communities felt that female drinking is on the rise, especially among young women raised in Canada. They attributed this trend mainly to acculturation and adoption of new, "Canadian" habits.

- **Most commonly consumed alcoholic beverages**

The results show differences in the alcoholic beverage preferences across the communities. In the Portuguese community, alcohol is traditionally synonymous with wine. Men in the community also commonly add whisky, brandy or "moonshine"[*] (Aguardente) to the morning coffee. "Sopas de vinho" ("wine soup" composed of bread, wine and sugar or wine added to collard or chicken soup) is still popular among the older Portuguese generation. Schlivovitz (plum brandy) is considered a traditional Serbian alcoholic beverage. Beer, wine and whisky were identified as the most popular beverages consumed in the Tamil community. "*People associate drinking with a*

[*] Home-made distilled liquor

social status and sophisticated life style." Tamil participants noted that some people still drink 'toddy' and 'arrack', local drinks from their home country, available from the local Tamil stores in Toronto.

- **Perception of "normal" drinking**

Focus group discussions revealed great differences in the perceptions of "normal" or socially acceptable drinking levels. Descriptions varied from two beers in the Somali community to 0.5 liter of vodka in the Russian community. In the Tamil community "*social drinking is accepted as long as the number of drinks taken is limited*", while the Punjabi participants noted that in their community there is no 'acceptable level' of drinking. *"The host's obligation is to 'force' guests to drink. The host is not concerned with others getting drunk, rather he is concerned with how much he could make them happy by 'pouring' drinks."* In the Serbian community "*people usually do not count. One can drink as long as he doesn't bother others.*" Counting and measuring drinks is generally not a habit in these communities.

- **Perception of "excessive" drinking**

While "excessive" drinking and alcohol intoxication is not condoned in any of the participating communities, occasional inebriation is well tolerated in the Russian, Polish, Portuguese, Serbian and Punjabi communities. According to the focus group participants, in some communities, including Russian and Serbian, men are expected to drink large quantities of alcohol. The ability to drink large amounts of alcohol is directly associated with masculinity. *"My husband can easily drink 20 oz of brandy. It's a matter of pride that you can drink a lot. It is viewed as very unfortunate (shameful) if you cannot drink."* (Serbian community member) However, the participants did not specify what they considered to be "excessive drinking" or described it in different ways. In general, they indicated that alcohol use is considered "socially unacceptable" when it starts "bothering others" or causing problems with family or social relations.

4.3 Differences in drinking patterns between the country of origin and Canada

Results reveal some differences in drinking patterns between the participants' home countries and Canada due to accessibility of certain alcoholic beverages, living circumstances, different lifestyles and stricter law enforcement, including enforcing the legal drinking age. "*In Russia we drink after work to relax, to warm up in cold weather and to take part in social activities. In Canada we drink mostly because of homesickness, loneliness and depression*." They also noted that alcohol in their countries was cheaper and easily available "*since the most stores that sell groceries also sell alcohol*." Polish community representatives suggested that in Canada people drink more often alone and on weekends, while in Poland "*people make more social occasions to*

have an excuse to use alcohol". Somali participants stressed that in Somalia people who consume alcohol try to hide themselves, while in Canada Somalis drink openly.

4.4 Community's perception of the risks and problems associated with drinking

The perceived risks and consequences of alcohol use also differ among the communities. Family violence and disruption, financial problems, drinking and driving, and legal problems have been identified as the most common alcohol-related problems. Interestingly, only three communities (Tamil, Punjabi and Polish) associated health problems with alcohol use. Russian participants noted that in their community, health problems are usually not viewed as a consequence of drinking*. "We actually drink to treat or prevent some illnesses*."

Traditional habits of alcohol use, social acceptance of drinking, the accessibility of alcohol and lack of community education about the consequences of excessive drinking are perceived as the major contributing factors to excessive drinking and alcohol related problems. "*I didn't even know that heavy drinking could cause hypertension. It wasn't until a family member became ill that this was acknowledged. I knew the liquor mustn't be good for him after he had the high blood pressure but I never knew excessive drinking could cause it!*" (Serbian community member) Participants from all seven communities identified a lack of knowledge about "problematic drinking" and alcohol addiction, and requested more information about the negative effects of alcohol to be disseminated to the community members.

- **Subgroups at risk**

Findings indicate that, in general, new immigrants, single men and those who are having financial or other difficulties, drink more than the general community due to the stress to which they are exposed. In some communities, such as Serbian and Punjabi, seniors (men) are seen to be prone to excessive alcohol consumption due to problems at home, isolation and loneliness. By contrast, the Somali community in Ottawa was concerned that a large percentage of Somali youth was starting to drink alcohol on a daily basis. The Portuguese community also felt that youth and younger men were more at risk of developing alcohol-related problems than older members of the community.

4.5 Perceptions of low-risk drinking

Focus group participants expressed different views about low-risk drinking practices and information about ways to avoid or reduce the risks associated with alcohol use. They also revealed different perceptions of "low-risk drinking". Russian focus group participants provided a

very “liberal” interpretation of low-risk drinking describing it as “*consuming reasonable amounts of alcohol and not every day*” or “*being able to control drinking and stop once you feel relaxed and happy”*. For Punjabi men “*Low-risk drinking means ‘you drink very little’. Little drinking will not harm you.*”

4.6 The concept of “standard drink”

The overwhelming majority of participants found the concept of a “standard drink” strange and confusing mainly because of the different types of alcoholic beverages they use, the different sized glasses or different drinking habits. For example, a large percentage of wine consumed in the Portuguese community in Toronto is homemade or purchased from local markets. The actual alcohol content of homemade or market bought wine is unknown, but is generally considered to be higher than 12% alcohol content. In addition, wine is usually not consumed from standard wine glasses. “*At home we drink from a jug at the table, or drink out of bowls which could be small to large.”* Focus group participants described the “standard drink” in the Punjabi community as being equal to a drink three times the size of the LRDG’s standard drink. Representatives of the Russian community couldn’t clearly define what they considered a “standard drink” to be, and described it as “50-100 grams of vodka or 2/3 – full 150 gram glass of wine”. They also noted that in their community, spirits are usually consumed without ice suggesting that this needs to be kept in mind when developing alcohol-related health promotion initiatives.

4.7 Perceptions of the Low-Risk Drinking Guidelines (LRDG)

A number of participants from different communities expressed concern that the LRDG are promoting drinking as normal and therefore encouraging alcohol use. Still, the results revealed that the LRDG are, in general, considered relevant and useful for all communities except Serbian and Somali. *“Formula 0-2-9-14 is very good and relevant to our community. It is opposite to the message Do Not Drink, which would not be accepted and nobody would pay attention to it*”. (Russian community member) However, the majority of participants found the brochure to be “too wordy” and suggested more pictorial images, “*more pictures, less words*”. Interestingly, all of the communities found the image of the glass containing spirits on the front page of the brochure to be disproportionably larger than both the wine glass and the beer bottle on the same page. They stressed that the picture should depict the correct (proportional) amount of liquor. The LRDG underwent vigorous testing before being released and, until now, nobody raised this concern.

Participants from the Punjabi community noted that although alcohol use is prohibited in the Sikh religion, and the only culturally appropriate messages are those focusing on abstinence, *“reducing the consumption may also be good for health and well-being of individuals*.” However,

the women's focus group expressed the need for an additional brochure that promotes complete abstinence. Portuguese participants considered the information about the ways to reduce the risks associated with alcohol use relevant and valuable to their community. They expressed the need for the guidelines intended for the Portuguese community to include information on homemade wine, coffee with alcohol and "moonshine" as well as information about the liability issues when hosting a function. The Tamil community also considered education on low-risk drinking to be important. "*When the message of total abstinence is no more possible, the message about low risk drinking is better than no message*." Still, the general comment was: *"Too much information in the brochure, too wordy and confusing."* They also stated that the numbers on the front page did not convey any message to them and suggested that information on how drinking affects the family, particularly children, should be prominent.

Participants in the Polish focus groups stressed that their community needs be educated as much as possible about the negative effects of excessive alcohol use, and advised on how to limit their use. The LRDG are considered acceptable and useful for the Polish community. "*An adequate knowledge about the risks associated with drinking would encourage the community to examine drinking habits and traditions*."

Participants representing the Russian community in Toronto noted that the picture on the LRDG brochure of a glass with alcohol and ice in it was not appropriate for their community since they usually did not put ice in spirits. They felt that the picture only gives an image of a higher amount of alcohol in a glass. Participants also stated that the brochure is not clear about the risks associated with alcohol use in women and suggested that two different brochures, one for men and one for women, should be developed.

The Serbian community seems to be at the lower level of community readiness for this health promotion program than the other communities. Participants in both focus groups stated that information about the ways to avoid or reduce the risks associate with drinking are not relevant to the Serbian community. Drinking is perceived as an established practice deeply rooted in the Serbian tradition that is "almost impossible" to change in adults. "*Drinking and driving is the only message getting through right now*." Participants also agreed that written information, such as the LRDG brochure, is not effective in raising awareness of or changing the drinking practices in the Serbian community, stating that visual images are considered to be much more effective. Information about the risks of drinking and driving as well as health risks associated with alcohol use was identified as relevant and necessary to increase the health literacy level in the community. Serbian key informants also suggested *"hosting guidelines for wives"* (women are the ones who serve the drinks) would also be an effective way of raising awareness. Community

members considered visual images showing a car crash scene and messages stressing the impact of drinking on the family are most effective in raising awareness of alcohol-related risks. Participants also noted that Serbian men, especially those who have arrived in Canada in the past twelve years, are well educated, which needs to be kept in mind when developing any health education material.

The Somali community found the LRDG culturally inappropriate because both their religion and culture prohibit the use of alcohol. Participants expressed concern that promoting alcohol reduction would lead some people to believe that the Somali community would tolerate alcohol consumption. They stressed that the only culturally acceptable message is the one promoting total abstinence from alcohol consumption. According to the members of the focus groups, the most effective way to avoid alcohol consumption is to educate the community about the risks associated with drinking, using messages that reflect the religious values and remind people of the religious consequences of alcohol use.

4.8 Culturally appropriate messages addressing alcohol use

The results reveal that family values are considered very important for all seven communities. Almost all of the communities considered messages that stress the impact of alcohol use on the family as most effective and culturally appropriate. *"Family is very important and valued by Russians and messages that trigger feeling of guilt for harming the family may have positive effect on drinking practices*." (Russian key informant) Participants generally felt that their communities also needed to be educated as much as possible about the negative effects of excessive alcohol use in order to change their "drinking habits". "*Men in particular need to know that alcohol could cause impotence, poor sex life, heart attack, liver problems, high blood pressure, feeling of anger and financial problems*". (Punjabi community member)

4.9 Effective means of communicating health messages

Ethnic mass media, especially radio and television, is definitely considered in all of the participating communities to be the most effective communication channel for health promotion/prevention programs. Participants from the Somali community emphasized: "*Somalis are oral society. Therefore, the best way is to use Somali TV and Radio program.*" Visual information is, in general, considered more effective for all of the participating communities rather than written information. "*People pay attention to a picture, they do not read a text*." (Russian focus group participant) Local newspapers are also considered useful communication channel. "*Brochures could also be included in a Portuguese newspaper distribution"*

All of the communities expressed the need for information on alcohol including the LRDG in their native tongue. "*Not everybody in the community understands English. More people will read it if it is in Russian*". The participants recommended that the LRDG brochures be available in the places that are important for their communities, for example in doctors' offices, local stores, churches and agencies providing services to the respective ethnocultural community. "*Don't bother handing out pamphlets at drinking establishments. However, it would be good to have a poster with a picture regarding LRDG in drinking establishments."* (Portuguese community member)

Some communities, such as Serbian and Russian, found visual images showing the consequences of heavy alcohol use, such as car accidents, much more appealing that written messages. Participants also communicated that, in order to be effective, messages need to be conveyed by people respected by the community, such as religious and community leaders, counselors and local physicians. Russian focus group participants stressed that the information about ways to avoid or reduce risks associated with alcohol will be effective only if presented as a choice and not as an order. "*Our problem is that we lived in the country with propaganda and we are very selective to what we hear*."

The focus group findings confirmed that alcohol drinking patterns and practices, perceptions of alcohol-related risks and culturally appropriate health education initiatives are largely influenced by cultural traditions, religious norms and consumption patterns in people's homelands. They show that the same program may not be appropriate or relevant to culturally different communities.

The findings also demonstrate that any health education initiative needs to be tested with the intended target audience before translating or producing materials. In addition, community education initiatives should use communication tools and channels identified by the community as most appropriate and effective. Results also indicate that service providers should reduce reliance on pamphlets and brochures and consider using posters, ethnic media, stage plays and other communication channels more often. If brochures are used to convey messages, they should have "*more pictures, less words*" for people to read and understand them. Focus group participants stressed that any health information should use culturally appropriate and familiar terms in simple language that is understandable to people at different literacy levels. They emphasized that active, meaningful involvement of community representatives in the development and implementation of community health education strategies is crucial for the success of any community education initiative.

The rapidly increasing proportion of culturally diverse populations requires service providers to adequately respond to diverse health needs and ensure equal access to health education resources for all Canadians. There is a strong suggestion from the literature that organizations that provide services to culturally diverse communities promote the development or adoption of protocols for cultural adaptation and translation of English materials. The best practices model and the manual, the final outcomes of this project, will provide a set of guiding principles, specific strategies and activities, which have been shown through research and evaluation to be effective in addressing mental health and substance use problems in ethnocultural communities. The manual will help service providers to develop culturally appropriate health promotion and prevention programs guided by principles of effectiveness

4.9 Summary of the Key Findings by Community

Community	Key Findings
Polish Community, Toronto	▪ Alcohol is considered an integral part of the Polish cultural tradition ▪ It is commonly used to mark celebrations, at social events and business meetings ▪ It is also used to cope with stress as well as for health reasons ▪ Male use of alcohol is clearly viewed as more socially acceptable than female alcohol consumption ▪ Excessive drinking is generally unacceptable and stigmatized ▪ New immigrants, especially those with no family in Canada, are considered more prone to excessive drinking due to “overwhelming stress” ▪ Financial problems, violent behavior, legal problems such as drinking and driving, injuries and death caused by drinking and driving, as well as mental and physical health problems are viewed as the main problems associated with alcohol use ▪ There is a lack of knowledge in the community on “problematic drinking” and addiction to alcohol ▪ Messages that stress the impact of alcohol use on the family are considered the most effective and appropriate ▪ The Low-Risk Drinking Guidelines (LRDG) are viewed as very useful and important for the Polish community ▪ Participants suggested that two different brochures in Polish, one for men and one for women, should be developed ▪ Participants also suggested a different layout for the LRDG brochure: *“first provide information/facts and at the end recommended numbers of drinks”* ▪ Messages should be communicated through local Polish newspapers, radio and TV and delivered by professionals from the community, such as family doctors, community workers, and at the church during the Sunday mass
Portuguese Community, Toronto	▪ Alcohol, especially wine, is an accompaniment to meals, social gatherings, celebrations and entertainment ▪ There is a general belief that alcohol is good for health and that eating more food protects people from getting drunk ▪ A large percentage of wine consumption is homemade or purchased

	from other sources (i.e. local markets) ▪ The actual alcohol content of homemade or market bought wine is unknown and is generally considered to be higher than 12% alcoholic content ▪ Wine is the most common alcohol beverage consumed ▪ Whisky, brandy or moonshine (Aguardente) is commonly added to coffee in the morning or is used after the dinner ▪ Offering alcoholic beverages is considered a sign of hospitality ▪ Measuring and counting drinks is not customary ▪ Participants couldn't describe "standard drink". People often drink from a jug at the table or out of bowls ▪ Drinking is considered acceptable *"as long as a person does not misbehave"* ▪ Single, separated, divorced men and widowers drink more than married men ▪ Drunkenness is taboo and denial of alcohol misuse is common ▪ Drinking and driving is common, and represents a serious concern in the community ▪ About the LRDG: o Information should be provided in simple language using culturally appropriate and familiar terms o Information on homemade wine, coffee with alcohol and beverages such as moonshine, as well as about liability issues when hosting a function, should be added o The brochure's graphic on the front panel of a glass containing spirits should contain no ice and be proportional to other two beverage containers ▪ The brochures in Portuguese should be distributed at community organizations such as the Abrigo Centre and St. Christopher House, doctor's offices, banks, grocery stores, hairdressers, social clubs, bars, LCBO stores and churches in the areas within the Portuguese community, and included in a Portuguese newspaper distribution ▪ Involving respected individuals, such as medical doctors, in promoting the LRDG would increase credibility of the message
Punjabi Community, Peel Region	▪ Although the Sikh religion prohibits the use of any intoxicant, alcohol use is widespread in the Punjabi community ▪ Alcohol has been widely accepted as an entertainment medium ▪ The Punjabi culture views serving alcohol as a sign of respect ▪ There is also a belief that alcohol is good for one's health ▪ Punjabi men are the main alcohol consumers ▪ Participants indicated that young women are starting to drink in Canada, but still not openly ▪ Alcohol use is believed to be more prevalent among men 30 to 50 years old ▪ Problems at home, isolation and loneliness were identified as the main factors that lead to excessive alcohol consumption ▪ Women noted that most men drink excessively, but they feel helpless because they are expected to "*stick with their husbands*" and keep the problems of alcohol abuse within the family ▪ Beer, whisky and brandy are the preferred drinks. ▪ The "standard drink" in the Punjabi community is equivalent to a "triple" standard drink in the brochure ▪ Counting drinks is not a custom ▪ There is "no acceptable level" of drinking, *"The host's obligation is to 'force' guests to drink"*

	▪ Family disruption is identified as a major consequence of alcohol use ▪ The community needs more information about the negative effects of alcohol, in particular, alcohol-related health risks ▪ Messages that respect cultural values are those focusing on abstinence ▪ Yet, culturally appropriate messages do not exclude messages that create awareness of sensible drinking ▪ The LRDG are considered useful for people who are already drinking ▪ The LRDG brochure translated in Punjabi should be distributed at doctors' offices, pharmacies and local grocery stores ▪ Local newspapers, and radio and TV hosts should also talk about reducing the consumption of alcohol in the Punjabi community
Russian Community, Toronto	▪ Alcohol use is socially accepted and widely spread, *" It has a long tradition in our culture"* ▪ Alcohol is used to relieve stress, treat illnesses and have a pleasurable time ▪ Offering alcohol to a guest as well as accepting a drink from a host "*is a custom, a sign of hospitality and respect*" ▪ Use of alcohol is acceptable for both men and women, although different norms apply ▪ New immigrants, single men and those who are having financial difficulties are believed to drink more than the general community ▪ The Russians drink a variety of beverages, "*We drink vodka, wine, beer, martini and occasionally fortified wine."* ▪ Participants couldn't clearly define what is considered a "standard drink" in the Russian community ▪ Measuring and counting drinks is not customary ▪ Excessive alcohol consumption is socially acceptable and people often drink "*until alcohol lasts*" ▪ Aggression as well as financial, family and legal problems are considered the most common risks associated with alcohol use ▪ Messages that stress the importance and value of family are considered most effective to address alcohol use in the Russian community ▪ Visual information is, in general, considered more effective than written information ▪ Information about ways to avoid or reduce risks associated with alcohol use was considered relevant to the community, but only if it was presented as a choice and not as an order ▪ To be effective, the LRDG information needs to be more specific about the health risks associated with alcohol use ▪ The picture on the front panel of the LRDG brochure showing a glass containing spirits should be proportional to other two pictures, and with no ice in it ▪ The participants recommended that the LRDG brochures in Russian be available in places that are important for the community, for example in doctors' offices ▪ Articles in local newspapers and posters in the subway are also considered effective communication tools ▪ Messages need to be communicated by people who are respected by the community and whose advice is valued, such as counselors, priests and physicians

Serbian Community, Windsor	▪ Alcohol consumption is widespread and an established practice ▪ Serving alcohol and consuming an offered drink is considered a sign of respect ▪ One or two drinks every day are considered beneficial for heart health and depression ▪ Male alcohol consumption is generally approved and almost universally practiced, but women are expected to either not drink or to consume small amounts on special occasions ▪ Although excessive use of alcohol is not commended, there is no stigma attached to intoxication ▪ The ability to drink large amounts of alcohol is directly associated with masculinity ▪ Alcohol is most frequently used at social functions and celebrations ▪ Spirits, especially Schlivovitz (plum brandy), beer and wine are the most common alcoholic beverages consumed ▪ Counting drinks is not customary ▪ Drinking is socially acceptable as long as it doesn't cause social or family problems ▪ Shame associated with alcohol addiction keeps the problem within the family ▪ Participants identified violence, financial problems, drinking and driving and family disruption as the main risks associated with drinking ▪ There is a lack of knowledge of the health risks associated with alcohol use ▪ Participants indicated that alcohol-related problems are more common among newer immigrants ▪ Information about ways to avoid or reduce the risks associated with drinking is not considered relevant to the Serbian community ▪ Drinking is viewed as an established practice deeply rooted in the Serbian tradition that is *"almost impossible to change in adults"* ▪ Visual images are considered to be much more effective than written information ▪ Information about the risks of drinking and driving as well as health risks associated with alcohol use was identified as relevant and necessary ▪ Visual images showing a car crash scene and messages stressing the impact of drinking on the family are defined as the most effective in raising awareness of alcohol-related risks. ▪ Developing a program that specifically targets women (they are the ones who serve alcohol) is also seen as a very valuable prevention tool ▪ The information should be published in the local Serbian newspapers, such as "Voice of Canadian Serbs", posted at Internet cafés for youth, and announced on the Serbian radio broadcasting out of Toronto ▪ Multilingual messages (including those in Serbian) on prime time TV would be an effective health education strategy. ▪ Posters are also seen as good communication tool
Somali Community, Ottawa	▪ Alcohol is taboo, prohibited by both social and religious norms ▪ Drinking is viewed as a shameful activity and people who use alcohol are considered outcasts

	▪ Yet, male drinking is somewhat socially acceptable ▪ If a woman does drink, she is likely to have a bad reputation forever ▪ Participants expressed concern that females' drinking is on the rise in Canada ▪ New immigrants are considered to be at the highest risk of alcohol problems ▪ Drinking most frequently occurs on weekends at bars, social gatherings, parties or sporting events ▪ Beer, wine and spirits, such as vodka, are described as the most common alcohol beverages ▪ Participants couldn't determine the size of a "standard drink" ▪ Most people drink out of the bottle and very few use actual cups or glasses ▪ Two to four bottles (of beer) or one or two shots of spirits per occasion are considered socially acceptable ▪ The perceived major risks associated with alcohol consumption include: family break down; financial problems; violence; use of other drugs; unemployment, and legal consequences ▪ Participants considered the LRDG culturally inappropriate because Somali culture prohibits the use of alcohol ▪ The only culturally acceptable message is one of total abstinence ▪ The most effective messages are those focusing on the risks associated with drinking and reflecting the religious values ▪ The most effective strategies to address alcohol use in the Somali community are: o Early education about risks o Information about health issues related to alcohol consumption o Parents educating their children on alcohol using the Islamic point of view ▪ "*Somalis are oral society. Therefore, the best way to convey a message is to use Somali TV and radio program*" ▪ Messages should be conveyed by the religious leaders, elders and community leaders
Tamil Community, Toronto	▪ Abstinence from alcohol is value strongly recommended by Hinduism ▪ However, alcohol consumption is generally accepted in the Tamil community ▪ Alcohol is most commonly consumed at social functions such as birthdays, wedding receptions, graduations, funerals and puberty ceremony ▪ Drinking is associated with a social status and sophisticated life style ▪ Drinking is tolerable for men, but is taboo for women ▪ Yet, alcohol use among women seems to become more open in Canada and the community is gradually accepting the idea of *"women having a drink at parties"* ▪ Alcohol is traditionally given to women after childbirth for the first few days to help *"relive body pains and regain energy that is lost during childbirth"* ▪ It is believed that many Tamil people start drinking in Canada "*in order to cope with stress caused by immigration, war trauma, unemployment, underemployment and loneliness*" ▪ The community tends to deny problems caused by excessive drinking due to social stigma attached it

	▪ Beer, wine, brandy and whisky are the most common liquors consumed ▪ However, some people still drink 'toddy' and 'arrack' (local drinks from back home) available at the local Tamil stores ▪ Drinking is considered socially acceptable "a*s long as there are no problems caused by the consumption of alcohol*" ▪ Family problems, such as separation, divorce and family breakdown are considered major consequences of excessive alcohol use ▪ The information on low-risk drinking is viewed as important for Tamil community ▪ Participants indicated that the LRDG would be more effective if *"more elaborate explanation is given"* in Tamil to explain effectively the concept of low-risk drinking ▪ The brochure also needs to be culturally adapted to reflect the community's cultural views ▪ The picture of a glass in the brochure should depict the correct (proportional) amount of liquor ▪ Family values and harmony need to be included in the message stressing the effects of alcohol on the family and particularly on children ▪ A message that alcohol use affects parental duties should be added ▪ Health messages should be communicated through temples, churches, medical professionals, advertisements in theatres, teachers in schools, and Tamil newspapers ▪ Participants also suggested workshops and plays can be performed in schools and in cultural shows ▪ Pamphlets in plain Tamil language with illustrations are also accessible and effective in conveying messages ▪ Local media, such as television and radio, are considered an effective way to disseminate health information

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